

**MILWAUKEE COUNTY BEHAVIORAL HEALTH DIVISION
COMPREHENSIVE ASSESSMENT**

A. RECORD MANAGEMENT

Client Medical Record Number: _____

Interview Date: _____

Introductory Comments (how can we help you, what brought you here today, etc.)

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B. FAMILY AND LIVING CONDITIONS

CURRENT RESIDENCE

<input type="checkbox"/> Street, Shelter, No fixed address, homeless	<input type="checkbox"/> Supervised licensed residential facility (Adult Family Home)	<input type="checkbox"/> Institutional Setting (Other)
<input type="checkbox"/> Permanent - own private residence or household, alone or with others, without supervision, includes persons 18 yrs. Or older (Adults Only)	<input type="checkbox"/> Supervised licensed residential facility (Group Home CBRF)	<input type="checkbox"/> Institutional setting (Nursing Home)
<input type="checkbox"/> Permanent - someone else's private residence, without supervision, includes persons 18 yrs. Or older (Adults Only)	<input type="checkbox"/> Jail or correctional facility	<input type="checkbox"/> Institutional Setting (ICF-MR/FDD/DD Center/State institution for people with developmental disabilities)
<input type="checkbox"/> Transitional - own private residence or household, alone or with others, without supervision, includes persons 18 yrs. Or older (Adults Only)	<input type="checkbox"/> Child under 18 living with relatives, friends	<input type="checkbox"/> Institutional Setting (Mental Health Institute/State psychiatric Institution {e.g. Mendota})
<input type="checkbox"/> Transitional - someone else's private residence, without supervision, includes persons 18 yrs. Or older (Adults Only)	<input type="checkbox"/> Child under 18 living with biological or adoptive parents	<input type="checkbox"/> Crisis Stabilization Home/Center
<input type="checkbox"/> Supported Residence – Residential care apartment complex or other supported apartment program (Adults Only)	<input type="checkbox"/> Foster Home	<input type="checkbox"/> Other living arrangements <input type="checkbox"/> Unknown
Is your current living arrangement a positive influence on your recovery?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Are you satisfied with your current living arrangement?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Do you feel safe in your current environment?	<input type="checkbox"/> Yes <input type="checkbox"/> No	

Housing instability within the last 12 months: ☐ Yes ☐ No ☐ Unknown

Check all that apply to indicate type of housing instability within the past 12 months

- ☐ Currently homeless (on the street or no permanent address) ☐ Homeless less than half the time in the past year
☐ Homeless more than half the time in the past year ☐ Has been evicted two or more times in the past year

Please discuss stability and instability factors

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Marital Status

☐ Divorced ☐ Annulled ☐ Married ☐ Significant Other or Partnered ☐ Separated ☐ Single

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<input type="checkbox"/> Never married <input type="checkbox"/> Unknown <input type="checkbox"/> Widowed	
How Long have you been in this marital status? (If never married, since age 18)	Years ____ Months ____
Are you satisfied with this situation?	<input type="checkbox"/> Indifferent <input type="checkbox"/> Yes <input type="checkbox"/> No
How many children do you have?	
How many children are under 18?	
How many of your children are living with someone else due to a child protection court order?	
For how many of your children have you lost parental rights? (the client's rights were terminated)	
How many of your children are in your legal custody? (Note: this question pertains to physical placement)	
Are you currently involved in Children's Court?	<input type="checkbox"/> Yes <input type="checkbox"/> No

Do you live with anyone who:

Has a current alcohol problem?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Uses Non-prescribed drugs?	<input type="checkbox"/> Yes <input type="checkbox"/> No

Describe the level of alcohol or other drug abuse in your current living situation

Can you live in this current environment without a high risk of relapse?

How many days in the past 30 days have you had serious conflicts:

With your family? _____	With other people? _____
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How troubled or bothered have you been in the past 30 days by these?

Family problems _____ <input type="checkbox"/> Extremely <input type="checkbox"/> Considerably <input type="checkbox"/> Moderately <input type="checkbox"/> Slightly <input type="checkbox"/> Not at all	Social problems _____ <input type="checkbox"/> Extremely <input type="checkbox"/> Considerably <input type="checkbox"/> Moderately <input type="checkbox"/> Slightly <input type="checkbox"/> Not at all
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How important to you now is treatment or counseling for these?

Family problems _____ <input type="checkbox"/> Extremely <input type="checkbox"/> Considerably <input type="checkbox"/> Moderately <input type="checkbox"/> Slightly <input type="checkbox"/> Not at all	Social problems _____ <input type="checkbox"/> Extremely <input type="checkbox"/> Considerably <input type="checkbox"/> Moderately <input type="checkbox"/> Slightly <input type="checkbox"/> Not at all
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Comments:

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C. EDUCATION AND EMPLOYMENT

Do you have a valid Driver's License?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Do you have an automobile available to you?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Current daily activities (Not including employment - must enter one – may enter up to three) <input type="checkbox"/> No educational, social or planned activity <input type="checkbox"/> Part time educational activity <input type="checkbox"/> Meaningful social activity <input type="checkbox"/> Volunteer or planned activities <input type="checkbox"/> Unknown <input type="checkbox"/> Other activities <input type="checkbox"/> Other Specify: _____	

What is the highest level of education you have finished, whether or Not you received a degree:
<div style="display: flex; flex-wrap: wrap;"> <div style="width: 33%;"> <input type="checkbox"/> 1st grade <input type="checkbox"/> 7th grade <input type="checkbox"/> 2nd grade <input type="checkbox"/> 8th grade <input type="checkbox"/> 3rd grade <input type="checkbox"/> 9th grade <input type="checkbox"/> 4th grade <input type="checkbox"/> 10th grade <input type="checkbox"/> 5th grade <input type="checkbox"/> 11th grade <input type="checkbox"/> 6th grade <input type="checkbox"/> High school Diploma or GED </div> <div style="width: 33%;"> <input type="checkbox"/> Some College or Technical School (Associate Degree or vocational tech. degree) <input type="checkbox"/> Bachelor's degree <input type="checkbox"/> Advanced degree, (Master's, PH.D) <input type="checkbox"/> Unknown </div> </div>

***Are you interested in getting help with any work or school related activities, such as job training or going back to school?**

☐ NO ☐ YES

Employment Status

<input type="checkbox"/> Full time competitive (35 or more hrs/week)	<input type="checkbox"/> Unemployed (looking for work past 30 days)	<input type="checkbox"/> Not in the labor force-retired
<input type="checkbox"/> Part time competitive (less than 35 hrs/ week)	<input type="checkbox"/> Not in the labor force-student	<input type="checkbox"/> Not in the labor force-disabled
<input type="checkbox"/> Part time irregular hours	<input type="checkbox"/> Not in the labor force-jail, prison, institution	<input type="checkbox"/> Not working for pay by choice
<input type="checkbox"/> Military or other service	<input type="checkbox"/> Not in the labor force-sheltered employment	<input type="checkbox"/> Unemployed due to legal problems
<input type="checkbox"/> Supported competitive employment	<input type="checkbox"/> Not in the labor force-other reason	<input type="checkbox"/> Not Applicable children 15 and under <input type="checkbox"/> Unknown

Interest in a job

<input type="checkbox"/> Interested in having a job	<input type="checkbox"/> Not Interested in having a job or a new job	<input type="checkbox"/> Interested in having a new job	<input type="checkbox"/> Wants to work, but is afraid of losing MA and SSA benefits
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Needs assistance to find/apply for work/school

<input type="checkbox"/> Not applicable	<input type="checkbox"/> Independent	<input type="checkbox"/> Needs assistance
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Needs assistance to function at a job, includes showing up on time, dressing appropriately, performing expected tasks, and performing in cooperation with others (does not include transportation)

<input type="checkbox"/> Not applicable <input type="checkbox"/> One to four times a month	<input type="checkbox"/> Independent <input type="checkbox"/> More than one time per week	<input type="checkbox"/> Less than monthly
How many days have you experienced employment problems in the past 30 days?		_____
How troubled or bothered have you been by these employment problems in the past 30 days? <input type="checkbox"/> Extremely <input type="checkbox"/> Considerably <input type="checkbox"/> Moderately <input type="checkbox"/> Slightly <input type="checkbox"/> Not at all		
How important to you now is counseling for these employment problems? <input type="checkbox"/> Extremely <input type="checkbox"/> Considerably <input type="checkbox"/> Moderately <input type="checkbox"/> Slightly <input type="checkbox"/> Not at all		

Approximately how much money did you receive in the past 30 days from:

a. Wages	\$ _____	<input type="checkbox"/> Don't know <input type="checkbox"/> Refused
b. Public Assistance	\$ _____	<input type="checkbox"/> Don't know <input type="checkbox"/> Refused
c. Retirement	\$ _____	<input type="checkbox"/> Don't know <input type="checkbox"/> Refused
d. Disability	\$ _____	<input type="checkbox"/> Don't know <input type="checkbox"/> Refused
e. Social Security	\$ _____	<input type="checkbox"/> Don't know <input type="checkbox"/> Refused
f. Non-legal income	\$ _____	<input type="checkbox"/> Don't know <input type="checkbox"/> Refused
g. Family and/or friends	\$ _____	<input type="checkbox"/> Refused
h. Other: Specify	\$ _____	<input type="checkbox"/> Don't know <input type="checkbox"/> Refused

Are you currently receiving any forms of public assistance? ☐ Yes ☐ No

Would you be interested in getting any help with any of the various forms of assistance? ☐ Yes ☐ No

Comments:

D. MILITARY FAMILY AND DEPLOYMENT

Have you ever served in the Armed Forces, in the Reserves, or in the National Guard?

- | | | |
|---|---|-------------------------------------|
| <input type="checkbox"/> Yes, in the armed forces | <input type="checkbox"/> Yes, in the National Guard | <input type="checkbox"/> Refused |
| <input type="checkbox"/> Yes, in the reserves | <input type="checkbox"/> No | <input type="checkbox"/> Don't know |

Are you currently on active duty in the Armed Forces, in the Reserves, or in the National Guard? If "Active" What area?

- | | | |
|---|---|-------------------------------------|
| <input type="checkbox"/> Yes, in the armed forces | <input type="checkbox"/> Yes, in the National Guard | <input type="checkbox"/> Refused |
| <input type="checkbox"/> Yes, in the reserves | <input type="checkbox"/> No, separated or retired from the
Armed Forces, Reserves, or National Guard | <input type="checkbox"/> Don't know |

Comments:

E. PHYSICAL HEALTH

How would you rate your overall health right now?

- ☐ Excellent ☐ Very good ☐ Good ☐ Fair ☐ Poor ☐ Don't know ☐ Refused

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How would you rate your overall quality of life?

☐ Very good ☐ Good ☐ Neither good nor poor ☐ Poor ☐ Very Poor

Do you have any chronic medical problems? ☐ Yes ☐ No

Please describe:

How important to you now is treatment for these medical problems?

☐ Extremely ☐ Considerably ☐ Moderately ☐ Slightly ☐ Not at all

***All current prescribed medications, OTC medications, vitamins, and supplements:**

Are you taking medication you have been prescribed according to schedule?		<input type="checkbox"/> Yes <input type="checkbox"/> No
Are you currently pregnant?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not applicable	
Do you know the due date?	<input type="checkbox"/> Yes <input type="checkbox"/> No	What is the due date? (mm/dd/year)_____

Have you seen a doctor or nurse for prenatal care? ☐ Yes ☐ No

Have you received treatments for physical complaints? If so, how many times?	Lifetime	Past 30 days
Inpatient treatment <input type="checkbox"/> Yes <input type="checkbox"/> No	_____	_____
Emergency Room Treatment <input type="checkbox"/> Yes <input type="checkbox"/> No	_____	_____
Outpatient Treatment <input type="checkbox"/> Yes <input type="checkbox"/> No	_____	_____

Health appointment healthcare - last six months	Health appointment vision care - last six months	Health appointment dental care - last six months
<input type="checkbox"/> Kept appointment <input type="checkbox"/> No appointment needed <input type="checkbox"/> Unable to access services <input type="checkbox"/> Did Not keep <input type="checkbox"/> Refused services <input type="checkbox"/> Unknown	<input type="checkbox"/> Kept appointment <input type="checkbox"/> No appointment needed <input type="checkbox"/> Unable to access services <input type="checkbox"/> Did Not keep <input type="checkbox"/> Refused services <input type="checkbox"/> Unknown	<input type="checkbox"/> Kept appointment <input type="checkbox"/> No appointment needed <input type="checkbox"/> Unable to access services <input type="checkbox"/> Did Not keep <input type="checkbox"/> Refused services <input type="checkbox"/> Unknown
*Psychiatric healthcare - last six months		

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- ☐ Kept appointment
☐ No appointment needed
☐ Unable to access services
☐ Did Not keep ☐ Refused services
☐ Unknown

How troubled or bothered have you been by these medical problems in the past 30 days?

- ☐ Extremely
 ☐ Considerably
 ☐ Moderately
 ☐ Slightly
 ☐ Not at all

Would you like to talk to someone about infectious or communicable diseases (e.g., Non HIV, STD, HIV, TB, Hepatitis C, etc.) to discuss whether or not you should be tested? ☐ Yes ☐ No

Please describe current treatment providers and contact information, as well as medical AND dental history:

F. MENTAL HEALTH

How many days in the past 30 days have you experienced any emotional or psychological problems? _____			
How much have you been bothered by these emotional or psychological problems in the past 30 days?			
<input type="checkbox"/> Extremely <input type="checkbox"/> Considerably <input type="checkbox"/> Moderately <input type="checkbox"/> Slightly <input type="checkbox"/> Not at all			
How important is it to you now for treatment for these psychological problems?			
<input type="checkbox"/> Extremely <input type="checkbox"/> Considerably <input type="checkbox"/> Moderately <input type="checkbox"/> Slightly <input type="checkbox"/> Not at all			
Have you ever:	Yes/No	Number of days in the past 30 days	Number of years in lifetime
Been prescribed medication for psychological/emotional problems	<input type="checkbox"/> Yes <input type="checkbox"/> No		
Are you taking medication you have been prescribed according to schedule?	<input type="checkbox"/> Yes <input type="checkbox"/> No		
Experienced serious depression?	<input type="checkbox"/> Yes <input type="checkbox"/> No		
Experienced serious anxiety or tension?	<input type="checkbox"/> Yes <input type="checkbox"/> No		
Experienced hallucinations (auditory, visual, or tactile – not related to your use of alcohol or drugs)?	<input type="checkbox"/> Yes <input type="checkbox"/> No		
Experienced trouble understanding, concentrating, or remembering?	<input type="checkbox"/> Yes <input type="checkbox"/> No		
Experienced mania (not related to your use of alcohol or drugs)?	<input type="checkbox"/> Yes <input type="checkbox"/> No		
Experienced trouble controlling violent behavior?	<input type="checkbox"/> Yes <input type="checkbox"/> No		

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Physical aggression (e.g., hitting/assaulting others, damage to property, fire setting). Includes Nonconsensual sexual aggression. ☐ Yes ☐ No

If Yes, check all time periods that apply.

☐ Lifetime ☐ Past 30 days

Physical aggression has resulted in the injured person being hospitalized (does not include ER visit only). ☐ Yes ☐ No

Have you ever:	Yes/No	Number of days in the past 30 days	Number of years in lifetime
Have you experienced homicidal thoughts or serious thoughts of physically hurting others?	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____	_____
Are you currently experiencing homicidal thoughts or serious thoughts of physically hurting others	<input type="checkbox"/> Yes <input type="checkbox"/> No		
Experienced serious thoughts of suicide?	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____	_____

Has had suicidal ideation with a feasible plan within the last 2 months? ☐ Yes ☐ No

Number of suicide attempts: Past 30 days _____ Lifetime _____

Self-injurious behavior (cutting, burning, pica, polydipsia, head banging) does NOT include suicide attempts.

☐ Yes ☐ No ☐ Unknown Check all time periods that apply: Within the past year _____ Past 30 days _____

Comments (please describe any suicide attempts, self-injurious behavior, assaultive behavior, or any other concerning behaviors or mental health symptoms):

Did you receive treatment for mental or emotional difficulties? If so, specify how many times.

Inpatient treatment <input type="checkbox"/> Yes <input type="checkbox"/> No	Past 30 days _____	In lifetime _____
Emergency Room treatment <input type="checkbox"/> Yes <input type="checkbox"/> No	_____	_____
Outpatient treatment <input type="checkbox"/> Yes <input type="checkbox"/> No	_____	_____

Chapter 51 Emergency Detentions (Brought to psychiatric ER by police)

Past 30 days: ☐ 1-3 times ☐ 4 or more times

Lifetime: ☐ 1-3 times ☐ 4 or more times

Treatment History:

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G. TRAUMA

Have you ever experienced violence or trauma in any setting (including community or school violence; domestic violence; physical, psychological or sexual maltreatment; assault within or outside of the family; natural disaster; terrorism, neglect or traumatic grief?

☐ Yes ☐ No ☐ refused ☐ don't know

Presence of emotional abuse? (Possible probes: in the past 30 days, has anyone persistently done or said things to ridicule or humiliate the client or to make them feel bad emotionally? This may include harsh words, humiliation, and manipulation.)

In the past 30 days? ☐ Yes ☐ No ☐ Unknown

In lifetime? ☐ Yes ☐ No ☐ Unknown

Presence of physical abuse? (Possible probes; in the past 30 days, has the client felt afraid of anyone? It may include a spouse, partner, child, or other family member. Does client feel safe physically? Has anyone hit or beaten the client? It may include slapping, punching, kicking, assaulting with a weapon)

In the past 30 days? ☐ Yes ☐ No ☐ Unknown

In lifetime? ☐ Yes ☐ No ☐ Unknown

Presence of sexual abuse? (Possible probes; in the past 30 days, has anyone had any kind of sexual contact with the client against their wishes (including fondling or attempted fondling, rape or attempted rape).

In the past 30 days? ☐ Yes ☐ No ☐ Unknown

In lifetime? ☐ Yes ☐ No ☐ Unknown

In the past 30 days, to what degree were you bothered by past experiences involving physical, emotional, or sexual abuse?

☐ Extremely ☐ Considerably ☐ Moderately ☐ Slightly ☐ Not at all

Did any of these experiences feel so frightening, horrible, or upsetting that, in the past and/or the present, you:

Have had nightmares about it or thought about it when you did Not want to?

☐ Yes ☐ No ☐ refused ☐ don't know

Tried hard Not to think about it or went out of your way to avoid situations that remind you of it?

☐ Yes ☐ No ☐ refused ☐ don't know

Were constantly on guard, watchful, or easily startled?

☐ Yes ☐ No ☐ refused ☐ don't know

Felt numb and detached from others, activities, or your surroundings?

☐ Yes ☐ No ☐ refused ☐ don't know

Comments

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H. SUBSTANCE USE AND ADDICTIVE DISORDERS

Have you used the following?

Substance	Yes/No	Number of days in the past 30 days
Any alcohol	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Alcohol to intoxication (5+ drinks in one sitting)	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Alcohol to intoxication (4 or fewer drinks in one sitting and felt high)	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Illegal drugs (including abuse/misuse of prescription drugs other than prescribed)	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Both alcohol and drugs (on the same day)	<input type="checkbox"/> Yes <input type="checkbox"/> No	
How much would you say you spent (in dollars) during the past 30 days on:	Alcohol \$ _____ Drugs \$ _____	
How many days in the past 30 days have you used tobacco		
Type of tobacco used	Type _____	
Are you interest in quitting tobacco?	<input type="checkbox"/> Yes <input type="checkbox"/> No	

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	Yes/No	Number of days in the past 30 days	Number of years of <i>problematic</i> use in lifetime	Route
Heroin	<input type="checkbox"/> Yes <input type="checkbox"/> No			<input type="checkbox"/> IV <input type="checkbox"/> Oral <input type="checkbox"/> Nasal <input type="checkbox"/> Smoking <input type="checkbox"/> Non-IV Injection
Methadone	<input type="checkbox"/> Yes <input type="checkbox"/> No			<input type="checkbox"/> IV <input type="checkbox"/> Oral <input type="checkbox"/> Nasal <input type="checkbox"/> Smoking <input type="checkbox"/> Non-IV Injection
Other opiates/analgesics	<input type="checkbox"/> Yes <input type="checkbox"/> No			<input type="checkbox"/> IV <input type="checkbox"/> Oral <input type="checkbox"/> Nasal <input type="checkbox"/> Smoking <input type="checkbox"/> Non-IV Injection
Barbiturates	<input type="checkbox"/> Yes <input type="checkbox"/> No			<input type="checkbox"/> IV <input type="checkbox"/> Oral <input type="checkbox"/> Nasal <input type="checkbox"/> Smoking <input type="checkbox"/> Non-IV Injection
Other sed/hyp/tranq	<input type="checkbox"/> Yes <input type="checkbox"/> No			<input type="checkbox"/> IV <input type="checkbox"/> Oral <input type="checkbox"/> Nasal <input type="checkbox"/> Smoking <input type="checkbox"/> Non-IV Injection
Cocaine	<input type="checkbox"/> Yes <input type="checkbox"/> No			<input type="checkbox"/> IV <input type="checkbox"/> Oral <input type="checkbox"/> Nasal <input type="checkbox"/> Smoking <input type="checkbox"/> Non-IV Injection
Amphetamines	<input type="checkbox"/> Yes <input type="checkbox"/> No			<input type="checkbox"/> IV <input type="checkbox"/> Oral <input type="checkbox"/> Nasal <input type="checkbox"/> Smoking <input type="checkbox"/> Non-IV Injection
Cannabis	<input type="checkbox"/> Yes <input type="checkbox"/> No			<input type="checkbox"/> IV <input type="checkbox"/> Oral <input type="checkbox"/> Nasal <input type="checkbox"/> Smoking <input type="checkbox"/> Non-IV Injection
Hallucinogens	<input type="checkbox"/> Yes <input type="checkbox"/> No			<input type="checkbox"/> IV <input type="checkbox"/> Oral <input type="checkbox"/> Nasal <input type="checkbox"/> Smoking <input type="checkbox"/> Non-IV Injection
Inhalants	<input type="checkbox"/> Yes <input type="checkbox"/> No			<input type="checkbox"/> IV <input type="checkbox"/> Oral <input type="checkbox"/> Nasal <input type="checkbox"/> Smoking <input type="checkbox"/> Non-IV Injection
More than one substance per day (including alcohol)	<input type="checkbox"/> Yes <input type="checkbox"/> No			<input type="checkbox"/> IV <input type="checkbox"/> Oral <input type="checkbox"/> Nasal <input type="checkbox"/> Smoking <input type="checkbox"/> Non-IV Injection
Other illegal drugs (specify)	<input type="checkbox"/> Yes <input type="checkbox"/> No			<input type="checkbox"/> IV <input type="checkbox"/> Oral <input type="checkbox"/> Nasal <input type="checkbox"/> Smoking <input type="checkbox"/> Non-IV Injection
Other legal drug	<input type="checkbox"/> Yes <input type="checkbox"/> No			<input type="checkbox"/> IV <input type="checkbox"/> Oral <input type="checkbox"/> Nasal <input type="checkbox"/> Smoking <input type="checkbox"/> Non-IV Injection
According to the interviewer, which substance is the major problem?				
<input type="checkbox"/> No problem <input type="checkbox"/> Heroin <input type="checkbox"/> Methadone <input type="checkbox"/> Other Opiates/analgesics <input type="checkbox"/> Inhalants <input type="checkbox"/> Alcohol <input type="checkbox"/> Other <input type="checkbox"/> Barbiturates <input type="checkbox"/> Cocaine <input type="checkbox"/> Amphetamines <input type="checkbox"/> Other sed/hyp/tranq <input type="checkbox"/> Cannabis <input type="checkbox"/> Hallucinogens				
How long since you last used this drug? Days _____ Hours _____ Age of first use _____				
How frequently do you use this drug? <input type="checkbox"/> 1-2 days per week <input type="checkbox"/> 1-3 days in the past month <input type="checkbox"/> 3-6 days per week <input type="checkbox"/> No use in the past month <input type="checkbox"/> Daily <input type="checkbox"/> Unknown				
In the past 30 days, have you injected drugs? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Refused <input type="checkbox"/> Don't know				
In the past year, have you injected drugs? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Refused <input type="checkbox"/> Don't know				
In the past 30 days, how often did you use a syringe/needle, cooker, cotton, or water that someone else used? <input type="checkbox"/> Always <input type="checkbox"/> Half the time <input type="checkbox"/> More than half the time <input type="checkbox"/> Less than half the time <input type="checkbox"/> Never <input type="checkbox"/> Refused <input type="checkbox"/> Don't know				
Have you ever overdosed on drugs? <input type="checkbox"/> Yes <input type="checkbox"/> No How many times: _____				
When was the last time you overdosed? _____				

Did You Receive Alcohol and Substance Treatment?

	Yes/No	Number of days in the past 30 days	Number of times in lifetime
Inpatient Treatment (not Detox)	<input type="checkbox"/> Yes <input type="checkbox"/> No		
Outpatient Treatment	<input type="checkbox"/> Yes <input type="checkbox"/> No		
Emergency Room Treatment	<input type="checkbox"/> Yes <input type="checkbox"/> No		
Detox	<input type="checkbox"/> Yes <input type="checkbox"/> No		
AODA Residential	<input type="checkbox"/> Yes <input type="checkbox"/> No		
In the past 30 days have you experienced cravings? <input type="checkbox"/> Yes <input type="checkbox"/> No			

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Have You:

Spent a lot of time either getting alcohol or drugs, using alcohol or drugs or feeling the effects of alcohol or drugs (high, sick)? <input type="checkbox"/> In the last 30 days <input type="checkbox"/> Not applicable <input type="checkbox"/> Not in the last 30 days but yes, in last year		
Kept using alcohol or drugs even though it was causing social problems leading to fights, or getting into trouble with other people? <input type="checkbox"/> In the last 30 days <input type="checkbox"/> Not applicable <input type="checkbox"/> Not in the last 30 days but yes, in last year		
Use of alcohol or drugs caused applicant to give up, reduce or have problems at important activities at work, school, home or social events? <input type="checkbox"/> In the last 30 days <input type="checkbox"/> Not applicable <input type="checkbox"/> Not in the last 30 days but yes, in last year		
Had withdrawal problems from alcohol or drugs like shaking hands, throwing up, having trouble sitting still or sleeping, or used any alcohol or drugs to stop being sick or avoid withdrawal problems? <input type="checkbox"/> In the last 30 days <input type="checkbox"/> Not applicable <input type="checkbox"/> Not in the last 30 days but yes, in last year		
Have the withdrawal problems been life threatening? (Such as delirium tremens, DTs). <input type="checkbox"/> Yes <input type="checkbox"/> No		
Are you currently having similar withdrawal symptoms? <input type="checkbox"/> Yes <input type="checkbox"/> No		
Have you ever used a substance to avoid or relieve withdrawal symptoms? <input type="checkbox"/> Yes <input type="checkbox"/> No		
Do you have family or friends who are able and willing to assist you with your withdrawal care? <input type="checkbox"/> Yes <input type="checkbox"/> No		
Have you ever had to lie to people important to you about how much you have gambled? <input type="checkbox"/> Yes <input type="checkbox"/> No		
Have you ever felt the need to bet more and more money? <input type="checkbox"/> Yes <input type="checkbox"/> No		
How many days in the past 30 days have you experienced:	Alcohol problems _____	Drug problems _____
How troubled or bothered have you been in the past 30 days by these?	Alcohol problems _____ <input type="checkbox"/> Extremely <input type="checkbox"/> Considerably <input type="checkbox"/> Moderately <input type="checkbox"/> Slightly <input type="checkbox"/> Not at all	Drug problems _____ <input type="checkbox"/> Extremely <input type="checkbox"/> Considerably <input type="checkbox"/> Moderately <input type="checkbox"/> Slightly <input type="checkbox"/> Not at all
How important to you Now is treatment for these?	Alcohol problems _____ <input type="checkbox"/> Extremely <input type="checkbox"/> Considerably <input type="checkbox"/> Moderately <input type="checkbox"/> Slightly <input type="checkbox"/> Not at all	Drug problems _____ <input type="checkbox"/> Extremely <input type="checkbox"/> Considerably <input type="checkbox"/> Moderately <input type="checkbox"/> Slightly <input type="checkbox"/> Not at all
Have you ever felt you should cut down or control your substance abuse? <input type="checkbox"/> Yes <input type="checkbox"/> No		

Would you like to learn more about recovery groups, the different types of groups available (AA, Smart Recovery, Women for Sobriety, etc.) or how to locate a group in your area? <input type="checkbox"/> Yes <input type="checkbox"/> No already involved <input type="checkbox"/> No not interested <input type="checkbox"/> Uncertain or Ambivalent
Would you like to be connected with someone who has experienced similar substance abuse issues for support, friendship, or membership to help guide you through recovery? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Uncertain or Ambivalent

Treatment History

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I. CRIMINAL JUSTICE

Have you ever been arrested? ☐ Yes ☐ No

How many times have you been arrested? Lifetime _____

Past 30 days _____ How many of these arrests were for new offenses? _____

Are you on electronic surveillance? ☐ Yes ☐ No

How many days have you been in jail or in prison? Lifetime _____ Past 30 days _____

Comments

Are you currently awaiting charges, trial, or sentencing?

☐ Yes ☐ No ☐ refused ☐ don't know

Are you currently on community supervision (e.g., probation, parole, ect.)?

☐ Yes ☐ No ☐ refused ☐ don't know

How serious do you feel your present legal problems are? (Exclude civil problems)

☐ Extremely ☐ Considerably ☐ Moderately ☐ Slightly ☐ Not at all

How important to you now is counseling or referral for these legal problems?

☐ Extremely ☐ Considerably ☐ Moderately ☐ Slightly ☐ Not at all

Do you have any current legal issues with which you would like help? ☐ Yes ☐ No

Comments

J. COMMUNITY LIVING SKILLS

Check box that reflects the needs of applicant as it pertains to needing assistance from another person, i.e., is unable to function successfully in these areas without assistance from others within the past six months. (Assistance includes monitoring, supervision, reminding, coaching, or direct service).

Benefits / Resource Management

Needs assistance to plan for, access, and navigate benefits (e.g., Section 8, SSI, SSDI, Medicaid, Medicare, insurance, etc.).

Does Not include money management, which is captured elsewhere: ☐ Yes ☐ No

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Comments
Basic Safety
Needs help from others because is unable to recognize immediately dangerous situations or to respond in an emergency. Does not include high risk behaviors commonly engaged in by the public (such as unsafe sex, drinking and driving, poor health habits). <input type="checkbox"/> Yes <input type="checkbox"/> No
Comments
Social or Interpersonal Skills
Needs assistance to effectively interact with others to have adult social relationships, and to carry out adult social or recreational activities according to personal preferences. <input type="checkbox"/> Yes <input type="checkbox"/> No
Comments
Home Hazards
Needs assistance to maintain basic living environment to avoid disease hazards, fire hazards (e.g., hoarding), and/or odors noticeable from outside.
<input type="checkbox"/> Independent <input type="checkbox"/> Less than monthly <input type="checkbox"/> One to four times a month <input type="checkbox"/> More than one time per week
Comments
Money Management
Needs assistance to manage finances for basic necessities (food, clothing, shelter). Includes needing assistance to handle money, pay bills, and to budget.
<input type="checkbox"/> Independent <input type="checkbox"/> Less than monthly <input type="checkbox"/> One to four times a month <input type="checkbox"/> More than one time per week
Comments
Basic Nutrition
Needs assistance to maintain eating schedule, obtain groceries and/or to prepare or obtain simple meals (and avoid spoiled foods). Does NOT include transportation, which is captured elsewhere.
<input type="checkbox"/> Independent <input type="checkbox"/> Less than monthly <input type="checkbox"/> One to four times a month <input type="checkbox"/> More than one time per week
Comments
General Health Maintenance

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Needs assistance to care for own health and to recognize symptoms. Includes managing health conditions (e.g., diabetes, hypertension) and making and keeping medical appointments. Does NOT include medication management, which is captured elsewhere.

☐ Independent ☐ Less than monthly ☐ One to four times a month ☐ More than one time per week

Comments

Managing Psychiatric Symptoms

Needs assistance by a person (other than a physician) to manage mental health symptoms (e.g., hallucinations, delusions, mania, thought disorders, etc.). Does NOT include AODA or general health symptoms.

☐ Independent ☐ Less than monthly ☐ One to four times a month ☐ More than one time per week

Comments

Hygiene and Grooming

Needs assistance to maintain basic hygiene and grooming.

☐ Independent ☐ Less than monthly ☐ One to four times a month ☐ More than one time per week

Comments

Taking Medication

Needs assistance with taking medications, medication administration and assisting with self-administration, which includes setup, reminders, cueing, and/or observation to ensure person takes medication. Includes all prescribed meds-psychotropics and others.

☐ Needs someone to administer regular IM injections

Comments

Assistance needed with other prescribed meds

<input type="checkbox"/> NA has No meds	<input type="checkbox"/> Independent	<input type="checkbox"/> Less than monthly	<input type="checkbox"/> One to four days a month
<input type="checkbox"/> Two to six days per week	<input type="checkbox"/> One or more times daily		

Comments

Monitoring Medication Effects

Needs assistance monitoring effects and side effects of prescribed medications. This includes recognizing effects and Noticeable side effects of prescribed medications, reporting medication effects or new problems to a prescribing professional, and/or following any medication or dose changes recommended by the prescriber. Includes all prescribed meds – psychotropics and others.

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<input type="checkbox"/> NA has No meds	<input type="checkbox"/> Independent	<input type="checkbox"/> Less than monthly	<input type="checkbox"/> One to four days a month
<input type="checkbox"/> Two to six days per week	<input type="checkbox"/> One or more times daily		
Comments			
Transportation			
Needs assistance to arrange for transportation, use public transportation, or drive and maintain a vehicle.			
<input type="checkbox"/> Person drives <input type="checkbox"/> Person cannot drive due to physical, psychiatric or cognitive impairment. Includes No driver's license due to medical problems (e.g., seizures, poor vision) <input type="checkbox"/> Person does Not drive due to other reasons. (lost license, has No car) <input type="checkbox"/> Person drives but there are serious safety concerns.			
Comments			
Physical Assistance			
Needs assistance to physically accomplish the following tasks (check all that apply):			
<input type="checkbox"/> Independent	<input type="checkbox"/> Dressing	<input type="checkbox"/> Mobility in home	
<input type="checkbox"/> Toileting	<input type="checkbox"/> Bathing	<input type="checkbox"/> Transferring	
Comments			

K. RECOVERY SUPPORT

In the past 30 days, did you attend any support group for mental health and/or substance abuse, any voluntary self-help groups for recovery (either faith-affiliated or Not faith-affiliated), or any other groups or meetings that support recovery?		
<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Refused <input type="checkbox"/> Don't know Estimate how many times _____		
In the past 30 days, did you have interaction with family and/or friends that are supportive of your recovery?		
<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Refused <input type="checkbox"/> Don't know		
To whom do you turn when you are having trouble?		
<input type="checkbox"/> No one	<input type="checkbox"/> Family member	<input type="checkbox"/> Refused <input type="checkbox"/> Other
<input type="checkbox"/> Clergy member	<input type="checkbox"/> Friends	<input type="checkbox"/> Don't know

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Please include information about the client's social support structure

L. SERVICE PLANNING CONSIDERATIONS

Do you prefer to receive services from someone who is :
<input type="checkbox"/> Of your ethnic, racial, and/or cultural group <input type="checkbox"/> Of a different ethnic, racial or cultural group <input type="checkbox"/> Ethnicity, race, and/or culture does not make a difference <input type="checkbox"/> Of your faith <input type="checkbox"/> Of a different faith <input type="checkbox"/> Of your same gender

Legal Status:

- ☐ Voluntary ☐ Settlement agreement (Stipulations) ☐ Involuntary (Chap. 51 - Commitment)
☐ Involuntary (Chap. 55 - Protective Services and Placement) ☐ Involuntary Criminal ☐ Guardianship (Chap. 54)
☐ Probation/Parole or Conditional Release

Stage of Treatment:

- ☐ Pre-engagement ☐ Engagement ☐ Early Persuasion ☐ Late Persuasion ☐ Early Active Treatment
☐ Late Active Treatment ☐ Relapse Prevention ☐ In Remission or Recovery

Comments